

INTRODUCTION

This report is the first report of the Indiana Medical Error Reporting System. This is a preliminary report and presents information about reportable events occurring in Indiana health care facilities between January 1, 2006 and December 31, 2006. The report is based on data received by the Indiana State Department of Health prior to February 26, 2007. Because health care facilities have approximately six months to review events and report, additional reportable events for calendar year 2006 will likely be received in the coming months. The final report for 2006 will be released in August 2007 once complete 2006 data has been received.

The focus of this report is data that may be used to improve patient safety. Data on the number of medical errors and type of errors has not previously been gathered by the Indiana State Department of Health. This initial report therefore provides a baseline on the number of medical errors occurring in Indiana health care facilities. The initial data shows that stage 3 or stage 4 pressure ulcers acquired after admission to the hospital, retention of a foreign object in a patient after surgery, and surgery performed on the wrong body part are the three most common areas for medical error. The goal of the Indiana State Department of Health is that this data will increase focus on these issues and promote the development of evidence-based initiatives designed to improve patient safety.

Indiana has a tradition of excellence in healthcare. Indiana's health care facilities are among the most advanced in the country. Indiana colleges and universities are recognized leaders in healthcare education and research. Healthcare professionals are often recognized for the dedicated and outstanding care provided to Hoosiers. It is imperative that Indiana continue to lead the way in improving patient care and health outcomes. The reduction of medical errors is an important component of continuing the Hoosier tradition of quality healthcare.

The goal of this report is to improve healthcare services by focusing on data-driven initiatives. With the growth and technical advancement of the healthcare system, maintaining and improving patient safety has become a complex and long term process. Patient care today involves a large number of healthcare professionals and health care facilities. With this larger and decentralized system, there is an increased potential for medical errors. While individuals may, and do, make independent mistakes, medical errors are more often a system failure resulting from inconsistent care practices between professionals or facilities or communication lapses within or between the many health care professionals or facilities providing care to a patient.

The initial data on medical errors reinforces the need for health care facilities and providers to collaborate on quality. In today's healthcare system, patient care is generally not limited to a single provider or facility. The reduction of medical errors requires collaboration to promote consistent healthcare practices and ensure appropriate communication between providers. The medical error reporting system will hopefully encourage a culture in which health care providers report potentially unsafe situations without fear of reprisal in collaboration towards improved healthcare.